Valor
Health Services

Patient Health History Information Form

Date: _____

Name (Printed): _____ DOB: _____

Allergies: _____

List ALL Medications you take, including over the counter (OTC) medications and supplements. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications:	OTC & Supplements:
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Recreational Drug Use: __ Current __ Past __ Never

Smoking: __ Current __ Past __ Never Packs/Day: __ Packs/Week: __

Alcohol: __ Current __ Past __ Never Drinks/Day: __ Drinks/Week __

Personal Medical History: (Check all that apply)

__ ADHD
__ COPD
__ HIV
__ Lupus
__ Anemia
__ Asthma
__ Sciatica
__ Stroke
__ Nosebleeds
__ Neuropathy
__ Heart Disease
__ Thyroid Disorder
__ Crohn's Disease
__ Anxiety
__ Bipolar
__ Depression
__ Psoriasis
__ Eczema
__ Emphysema
__ Headaches
__ Liver Disease
__ Glaucoma
__ Sleep Apnea
__ Carpal Tunnel
__ Kidney Stones
__ Cancer: _____
__ Alcoholism
__ Dementia
__ Peptic Ulcer
__ Hepatitis
__ Diverticulitis
__ Gallstones
__ Migraines
__ Heart Attack (MI)
__ Ulcerative Colitis
__ Hiatal Hernia
__ High Blood Pressure
__ Bleeding Problems
__ High Cholesterol
__ Allergies, Seasonal
__ Irritable Bowel Syndrome
__ Diabetes: 1 or 2
__ Pulmonary Embolism (PE)
__ Peripheral Vascular Disease
__ Bladder Problems/Incontinence
__ GERD (Acid Reflux)
__ Macular Degeneration
__ Osteopenia/Osteoporosis
__ Parkinson's Disease
__ Rheumatoid Arthritis

Other Medical problems not listed above:

_____
_____
_____
_____

Surgical History: Please list all prior surgeries & approximate dates performed:

_____
_____
_____
_____

Last Menstrual Period	Date or N/A: _____	__ Normal	__ Abnormal
Colonoscopy	Date or N/A: _____	__ Normal	__ Abnormal
Mammogram	Date or N/A: _____	__ Normal	__ Abnormal
Dxa (Bone Density)	Date or N/A: _____	__ Normal	__ Abnormal

Family History

Father: __ Living __ Deceased Age: ____ (or at time of death)

__ Alcoholism	__ Blood Cancer	__ Migraines	__ Bipolar
__ Skin Cancer	__ Colon Cancer	__ High Cholesterol	__ COPD/Emphysema
__ Stroke	__ Heart Disease	__ Lymph Cancer	__ Thyroid Disorder
__ Anemia	__ Asthma	__ Breast Cancer	__ Dementia
__ Depression	__ Kidney Disease	__ Prostate Cancer	__ Blood Clot/DVT
__ Arthritis	__ Thyroid Cancer	__ Diabetes 1 or 2	__ High Blood Pressure
__ Osteoporosis	__ Other:		

Mother: __ Living __ Deceased Age: ____ (or at time of death)

__ Alcoholism	__ Blood Cancer	__ Migraines	__ Bipolar
__ Skin Cancer	__ Colon Cancer	__ High Cholesterol	__ COPD/Emphysema
__ Stroke	__ Heart Disease	__ Lymph Cancer	__ Thyroid Disorder
__ Anemia	__ Asthma	__ Breast Cancer	__ Dementia
__ Depression	__ Kidney Disease	__ Prostate Cancer	__ Blood Clot/DVT
__ Arthritis	__ Thyroid Cancer	__ Diabetes 1 or 2	__ High Blood Pressure
__ Osteoporosis	__ Other:		

Siblings:

Brother/Sister	Sex	Age or age at death

Patient Signature: _____Date: _____

Provider Reviewed: _____Date: _____